



# contact

A bimonthly publication of the

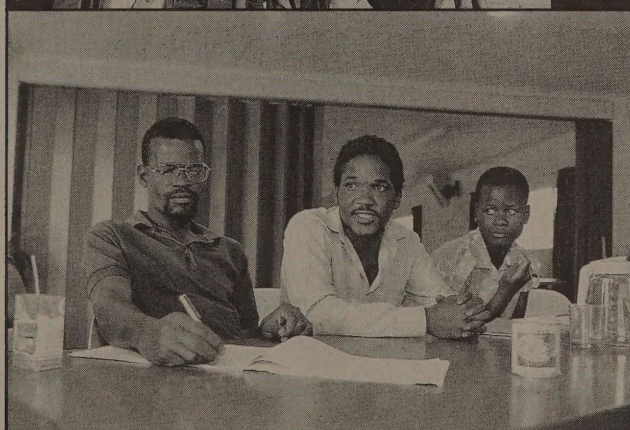
CMC – Churches' Action for Health  
150, route de Ferney

1211 Geneva 2

World Council of Churches  
Switzerland

No 137  
June  
1994

## COORDINATING AGENCIES



**Churches working together for health**

## INTRODUCTION

CMC's founding director, James McGilvray was a pioneer in coordinating the work of church-related health institutions. Ever since, CMC has provided support for health coordinating agencies in a variety of ways.

For example, approximately every three years, CMC organizes an international meeting to review progress in the work of the coordinating agencies. A meeting is currently being planned for the near future.

Regional meetings take place more frequently. A meeting in which many coordinating agencies were represented recently took place in East Africa. Entitled "Christians in Health Care: Present and Future", the meeting revealed the extent of the contribution that church-related health services were making in parts of Africa. In **Zaire** - 85% of health care is provided by the churches, and in **Tanzania** and **Uganda** - 40% of health care is provided by churches.

Between meetings, CMC - Churches' Action for Health works closely with coordinating agencies in many countries. For example, CMC's capacity-building programme organized a meeting in 1990 for countries of West

Africa. One of the results has been the national programme of community-based health care training by CHASL, the coordinating agency in Sierra Leone (featured on page 7).

One of the most important functions that has been instituted by health coordinating agencies has been the central or bulk buying of pharmaceuticals. Guidance and support in this work has been provided by CMC's essential drug programme. From its Geneva base, CMC has close links with the World Health Organization, the body which coordinates the essential drugs programme worldwide.

CMC has worked with the Christian Medical Board of Tanzania, Uganda Protestant Medical Bureau and the Eglise du Christ au Zaire in introducing Participatory Action Research (PAR) on AIDS. All three agencies say that the focus-group community discussions has stimulated humane care and support for people living with HIV/AIDS. Subsequently, through learning about the experience of PAR in Central and East Africa, the Nigerian coordinating agency, CHAN, has been able to use this successful approach to stimulating community action in West Africa. (See page 15).

Finally, *Contact*, CMC's publication, does its best to provide the coordinating agencies with a voice. This issue provides a special opportunity to let them speak.

---

### Coordinating agencies

Coordination: What does it take? .....	1
Coordinating agencies in action .....	5
Leading the way in community participation .....	7
Benefiting from central supplies .....	10
Updates from around the world .....	13
A vision for the future .....	16
Announcements .....	Back page

---

COVER

All four photos by Peter Williams/WCC

# COORDINATION: WHAT DOES IT TAKE?

*When Christian health agencies decide to think about coordinating their efforts, they often want to draw on the experience of those who have gone before. This article provides that opportunity. Stuart Kingma, who was CMC associate director 1975-1980 and CMC director 1981-1983, reviews the history of church health-related coordinating agencies.*



Peter Williams/WCC

Stuart Kingma

Coordination has been a recurrent theme among those involved in management, administration, planning and development work. Coordination provides a planning and management framework in which to enhance the effectiveness of a programme, extend its benefits, and

make the most of all the resources available in a particular sector.

Whenever there is a mix of actors and agencies involved in any given programme of work, an openness towards the needs and opportunities for coordination is a necessary state of mind. It is an important and positive element to consider in almost every aspect of international health.

Although this positive view of cooperation reflects the situation in development cooperation in the 1980s and 1990s, those involved in development have not always put an emphasis on the need for joining together to achieve certain targets. During the golden age of international development activity in the 1950s and 1960s, most groups were primarily concerned with establishing their own sphere of responsibility and competence. During that period, the Christian medical missions were also growing rapidly. For the most part, their priorities were not different. Coordination did not yet influence the flourishing non-governmental sector.

Yet, it was in this setting that in the late 1960s, the then Christian Medical Commission (CMC) suggested the value of coordination. To be absolutely correct, it was the founding Director

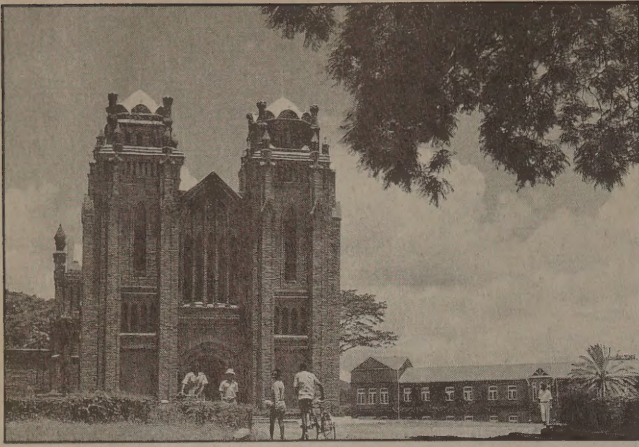
of the CMC, James ("Mac") McGilvray who captured this vision. During his service as a missionary in the Philippines in the 1950s, he had experienced the benefits of cooperation between programmes run by different churches and agencies and between the church-related programmes and the government. This formed the roots of the coordination thrust that CMC launched in the 1960s.

## Defining coordination

What are the real issues in coordination? How do they affect the coordinating efforts of church-related and other non-governmental health programmes in developing countries? Webster's Collegiate Dictionary provided a good jumping-off point. It defines "coordination" as "the act or action of coordinating" and the verb to "coordinate", as follows:

- to bring into a common action, movement or condition;
- to harmonize;
- to be or become coordinated, especially so as to act together in a smooth, concerted way.

It was the process of bringing church-related health programmes into "common action" that James McGilvray had achieved in the Philippines. The dialogue that he stimulated among the churches and mission hospitals in the Philippines led to the formation of the Inter-Church Commission on Medical Care (ICCMC) in 1958. Under the ICCMC, the various health programmes realised a number of managerial benefits. For example, they organized joint importation of equipment and supplies. At their regular meetings, they pursued a lively dialogue on the role of church institutions in the national scene.



During the 1950s and 1960s, church medical missions were growing rapidly and they had not established the need to coordinate their activities as a priority.

With this positive experience in mind, it was natural for James McGilvray to consider the issue of coordination to be important for other church-related health care programmes. Thus, when he began to undertake surveys of church health programmes in various countries during the 1960s, he included questions about cooperation, collaboration and coordination. It was the findings of these surveys which ultimately led to the formation of the Christian Medical Commission, within the World Council of Churches, in 1968.

### Malawi survey

The experience of the survey undertaken in Malawi provided a vivid insight into the energy that could be released when people discovered the benefits of taking a few simple steps in coordination. The survey was undertaken in 1965 at the request of the National Council of Churches in Malawi. According to a CMC report of the Third Conference for Coordinators of Church-related Health Work in Africa, held in Mombasa, Kenya, 18-21 February 1975:

*"What began as an exercise limited to the Protestant churches quickly became ecumenical when the surveyor was asked by a Catholic Bishop if he would include their institutions in the study. With the approval of the NCC (National Council of Churches), he did so.*

*"The survey began with an examination of the government's development plan for health services. There was no reference to church-related programmes in it, even though they constituted 40% of the existing facilities. The*

*reason for this omission is not as strange as it may appear. There were 26 church-related organizations operating these institutions, and they had no common voice. As the Life President of Malawi expressed it, 'They are all playing in their own backyards and they never look over the wall.' In such a situation, planning is impossible.*

*"At the conclusion of the survey, those whose institutions had been examined were asked to assemble to hear the results of the study and its recommendations. The first of these was that they disregard the labels on their doors because labels never cured anybody but tended to inhibit dialogue. [It was further recommended that] they should form an association to coordinate their activities and engage in joint planning amongst themselves and, collectively, with government. This they did ..."*

Many similar stories could be told. A succession of groups came together to discover the benefits of coordination. It was clear that more could be accomplished, efficiently and with resource savings, if individual church-related health programmes came together to "become coordinated, especially so as to act together in a smooth, concerted way".

After Malawi, six other groups in Africa came together with the encouragement of CMC. The Church Hospital Association of Ghana (CHAG) was formed in 1967, followed by the Churches' Medical Association of Zambia (CMAZ) in 1968, the Association of Rhodesian Church-Related Hospitals (ARCH)\* in 1973, and the Association of Medical Missions in Botswana (AMMB), the Christian Health Association of Nigeria (CHAN) and the Private Health Association of Lesotho (PHAL) in 1974. The Association formed in Lesotho was among the first of the groups to extend full membership to non-governmental organizations (NGOs) that were not church-related.

It was truly remarkable how this movement brought people together for the first time. Church groups not known for their willingness to join with other "mainline" Catholics and Protestants became part of the movement. Protestant and

Catholic agencies began to plan together and to coordinate with each other and with their governments. They came to realise that sharing and cooperating provided them with an opportunity to reflect their common mission. In the past, they had often found that their hospitals were competing with each other for patients.

### Progress in Asia

There were also early signs of movement towards cooperation in Asia. Following the example set in the Philippines, the Coordinating Committee for Christian Medical Programs in Taiwan was formed in 1967. In India, the Catholic Health Association of India and the Christian Medical Association of India already existed. In 1969, in conjunction with CMC, these two bodies came together to form the Coordinating Agency for Health Planning (CAHP). Later, associations of health programmes were established at state and regional levels in India. These joined CAHP to form the Voluntary Health Association of India (VHAI) in 1974.

Initiatives in coordination moved more slowly in French-speaking countries of Africa and in Latin America for a variety of reasons. Probably the most important of these was the fact that in the early days the CMC had not been able to recruit staff with the necessary competence, experience and languages to foster operations in these regions. This finally began to change in the late 1970s and 1980s. (Some current developments are featured on page 13.)

### Options in coordination

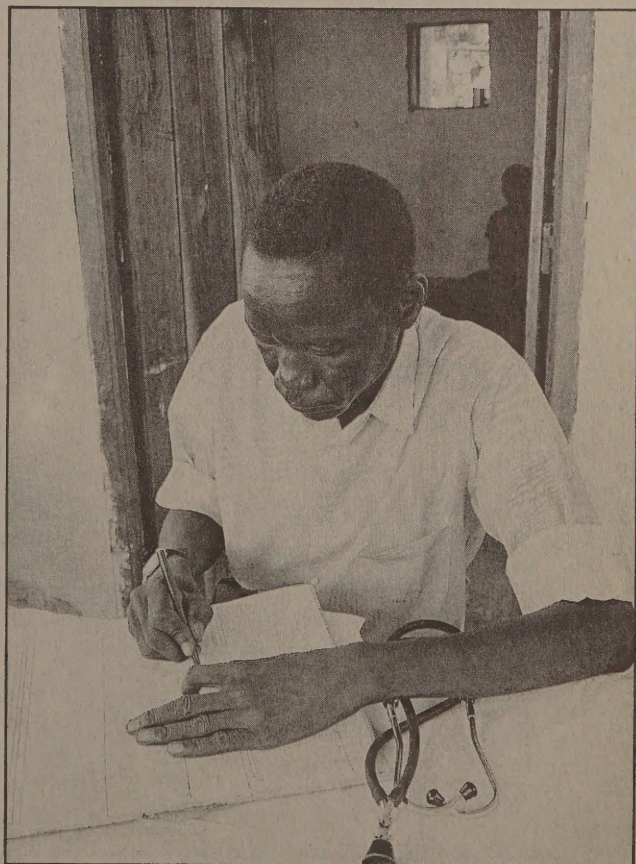
In some places, the shift to full-scale coordination through an established agency took place easily. Sometimes, the agency was even able to staff an office through funds drawn from a membership fee. In other countries, the church-related health programmes chose to cooperate in less formal ways and did not form "coordinating agencies" *per se*.

In some countries, the parent churches of health programmes chose to avoid any formal links of an ecumenical nature. In others, local programme managers felt that coordination would cause a loss of autonomy or demand an

unacceptable compromise on principles. Where such views were held, any movement towards coordination was halted, at least for a time. Staff in some NGOs felt that cooperation with government was only justified if the government would acknowledge that it had as much to learn from the NGO experience as NGOs had to learn from government. Unfortunately, it was often these same individuals who backed off close engagement if it meant submission to the discipline of established national health policy.

For some, formal coordination was seen as a means to better organization of the business side of health care. The attractions of forming an agency included:

- the opportunity to join together to put pressure on government to grant import duty exemptions for voluntary agencies;
- cheaper pharmaceutical supplies through bulk purchase with other agencies; and,
- lobbying government to increase programme subventions, bed grants, salary subventions and training grants.



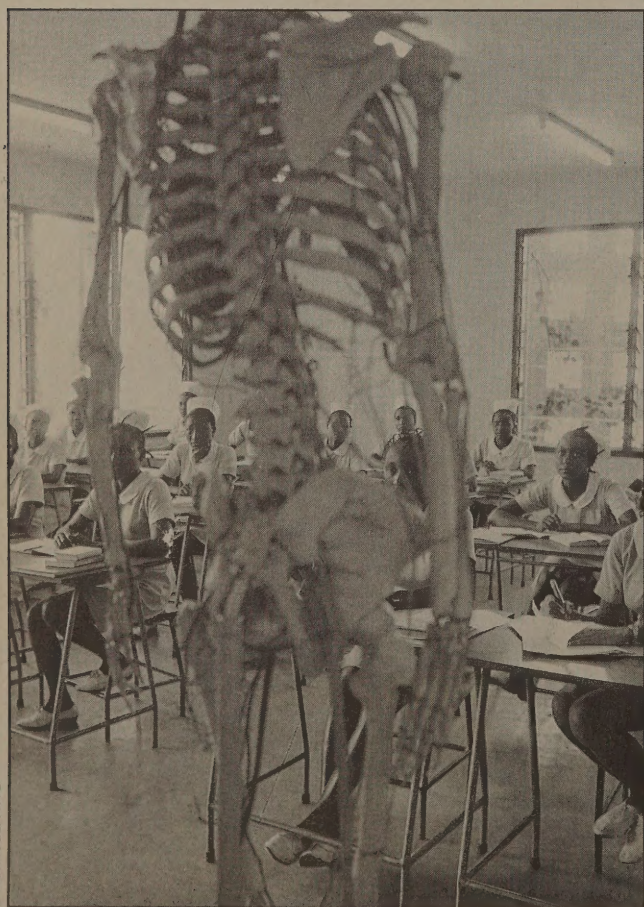
At independence, church-related health programmes formed 40% of existing services in some countries.

Margaret Murray/WCC

In many cases, coordination offered the choice of exploring a wider range of benefits than simply the practical and the administrative. The opportunities to benefit have flowered in many directions.

### **Harmonization of policies and programme approaches**

This has been one of the first appreciable benefits of dialogue and coordination efforts. It has not meant that any one group or agency has been dictating to the others. However, it has provided an opportunity for building consensus and avoiding confusion on health issues. For example, it has meant that those who supported community health action and primary health care in the early days had a platform from which to influence both other NGO programmes and governments. It has also helped to encourage agencies to follow the officially-approved government health care policies as far as they could. At the same time, collaboration among NGOs also helps to identify political issues which they may wish to bring to the government's attention.



D. Henrioud/WHO

During 1960s, many church health programmes in countries of Africa came together to discover the mutual benefits of joint training programmes.

### **Division of responsibilities among cooperating agencies**

This has been another positive outcome. It has proved possible to share responsibilities on a geographical, programmatic or service basis. This has helped to assure a more consistent range of health care provision. Sharing responsibilities makes good practical sense in the light of the limited resources available in most situations. Church-related programmes should not compete with one another. Duplication of services should be minimized in order to avoid the waste of human, material and financial resources involved.

### **Working together on particular issues**

This has offered major benefits which have sometimes gone far beyond what had originally been anticipated. In fact, experience has shown that when two or more programmes decide to find ways to pool resources, all kinds of good things happen. A higher standard of care can be achieved and services can be more complete and available at lower cost. All this is of real benefit for the health of communities and of families in those communities. Examples of these dynamic areas of cooperation would include joint training activities and the now well-known joint pharmaceutical procurement and distribution agencies.

Coordination is definitely worth both the effort and the resources invested. A visit to the field or a conversation with someone involved in joint action will dispel any doubts about the value of coordinating activities.

When considering an initiative in coordination, it is not important whether or not a formal agency is formed. What is important is that the coordinated programme is managed in harmony with others, including the government in any particular country, and that plans are made so that all those involved can work together in a smooth and concerted way.

Stuart J Kingma MD, is currently responsible for fund-raising, Global Programme on AIDS, World Health Organization, Geneva, Switzerland.

\* At Independence, the name changed to Zimbabwe Association of Church-related Hospitals (ZACH).

# COORDINATING AGENCIES IN ACTION

The following questions and answers are intended to provide readers with an outline of the policies and the services of the coordinating agencies, their problems as well as their structure and financing. The profile was developed both from information and materials sent to us by coordinating agencies and from interviews with those working in coordinating agencies and with CMC staff.

## Do all coordinating agencies share the same ideals and policies?

Christians coming together to form church health-related agencies are concerned that there is an important dimension to health that is often forgotten - spiritual well-being. This concern implies a need:

- to assist and enable churches in the health and healing ministry
- to become involved in issues of social justice, particularly in the provision and distribution of health services, and
- to promote the belief that people have an important part to play in their own health.

Coordinating agencies accept the need for both primary health care and appropriate referral and training centres and hospitals. They recognise that it is primarily the duty and responsibility of government to provide health care services, yet believe that voluntary agencies have a crucial role to play in the process.

Those involved in coordination also believe in the strength of fellowship and community, the need to provide a sense of belonging and the value of sharing. They also believe in the need to oppose competition between denominations, training centres and hospitals.

## What services can a coordinating agency provide?

### 1. Information

This may include publications and a resource centre, or a more modest collection of information about government programmes, sources of funding, writing project proposals and so on.

### 2. Expertise

Staff or agency members may be able to provide advice on how to start a new community health programme, alternatives for waste disposal as well as a range of expertise on improving the quality, coverage and effectiveness of health services.



One of the objectives of coordinating agencies is to advocate for the health needs of the people.

Peter Williams/WCC

### 3. Training

Short-term, long-term, formal and informal programmes may be available and courses may include formal medical education, community involvement in primary health care and promotion of the healing ministry.

### 4. Formal evaluations

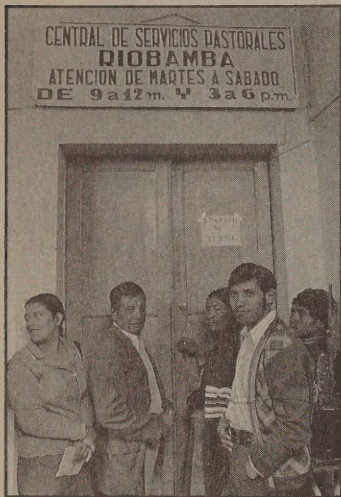
Coordinating agencies have the potential to offer supportive yet accurate evaluations of effectiveness.

### 5. Support as an intermediary

- Through representation on a hospital or health services board, coordinating agencies can intermediate between funders, including the government, and hospital staff who represent part of the membership of the coordinating agency.
- By organizing the central purchasing commodities, including pharmaceuticals, equipment and health education materials, costs to members can be reduced.
- By receiving and channelling resources, coordinating agencies can help members reduce financial complexities.
- By being familiar with many church-related health programmes, coordinating agencies are able to screen projects on behalf of potential donors.

## What are the main problems faced by a coordinating agency

**Sharing responsibility:** Because a coordinating agency is often an ecumenical body, it is owned by everyone. However, it is not always seen by the members to be their responsibility. Coordinating agencies are involved in a constant struggle to make the membership feel that they "own" and are responsible for the decisions made and the action taken.



Sebastiao Salgado/WCC

Coordinating agencies promote the belief that people have an important part to play in their own health.

**Recognition of limitations:** Coordinating agencies not only have to decide which priority areas they wish to limit themselves to, they also have to convince churches and members that limiting the agency to a few priorities is a requirement for success.

The skills and style required to run a successful coordinating agency are those of social management. A coordinating agency is often organized as a registered charity or society. These skills are different from those required for central purchasing and for channelling resources from outside donors to local projects. It may be appropriate for coordinating agencies to help build private companies to undertake this type of work rather than becoming directly involved in such activities.

**Relations with government:** Finding a balance in its relationship with government is a major challenge for any coordinating agency. On the one hand, government may be a source of funding. Coordinating agencies also want to be listened to by governments. However, the role

of coordinating agencies in advocacy for the poor and underserved often requires them to pose questions on difficult and sensitive topics.

Although government regulations are often necessary and important, some may impose restrictions which, unless accommodated or challenged, may suffocate certain projects.

## What is the structure of a coordinating agency?

Coordinating agencies frequently decide on the following formal structure:

**Membership** - open to Christians, Christian organizations and institutions. Members would be invited to an assembly once or twice per year.

**A steering committee**, representing the members and forming the membership of standing committees on, for example, education, scholarships, finance, national advisory, and so on.

**A board of management**, meeting two or three times a year and including the general secretary.

**A secretariat** - directed by the general secretary and comprising departments, such as community health, education and training, and administration. There might also be area offices and sections to represent different types of members, eg doctors, nurses, paramedics, administrators and chaplains. Area offices are often run by area managers assisted by honorary regional secretaries and their regional committees.

## How is a coordinating agency financed?

Many coordinating agencies began life coordinating hospitals and health services run by missionaries. As a result, they have often been overly dependent on funds from abroad. Today, in order to ensure a stable income, many agencies prefer a mixture of funding sources. These may include: membership fees; fees for services, such as consultancies; endowments (interest from investments); income generating activities, such as sales of health education materials, information booklets, formularies and text books; contributions from government and in-country foundations and trusts; and contributions from international donors and resource agencies.



## SIERRA LEONE

### LEADING THE WAY IN COMMUNITY PARTICIPATION

*The Christian Health Association of Sierra Leone (CHASL) coordinates on behalf of a membership of seven hospitals, 37 health centres and clinics and represents over 30% of the country's health care services. One of CHASL's objectives is to extend health care to a larger proportion of Sierra Leone's population. Here, executive director Marion Morgan\* describes how CHASL is bringing about wider coverage of health services by promoting the community-based approach to health care and development.*

CHASL's overall objective is to promote the best possible health care for the greatest number of people in Sierra Leone. We believe that this can be achieved through:

1. greater sharing of human and material resources;
2. fostering of communication and cooperation among the members themselves and between CHASL and government;
3. joint planning based on information collected from surveys of people's needs; and,
4. searching for alternative methods of health care provision for the many people not yet reached.

During our first ten years, we concentrated on the first three objectives of greater sharing of resources, better communication and joint planning. These were achieved through regular meetings of the CHASL membership, special seminars and workshops on current health problems, and the processing of requests for bulk purchases of pharmaceutical products.

By 1985, we were still not managing to fulfil the fourth objective. There was still a need to seek out "alternative methods of health care provision for the many people not yet reached." It was this unachieved goal that attracted me to accept CMC's invitation to participate in the training workshop for community-based health care/development (CBHC/D). Held in Cotonou, Benin in June 1990, the main objective of the workshop was to enable participants to become



All the villages had traditional birth attendants but none of them were trained.

skilled in participatory training for community-based health care and development. For me, it was a new concept and I learnt a great deal.

#### Getting started

On my return to Sierra Leone, I felt that my challenge, as executive director of CHASL, was to promote the concept of CBHC/D. Through CHASL, this new concept could be used as a means extending health care to more people in Sierra Leone. What was needed was not only to convince CHASL members but also to convince church leaders, medical people and the general public nationwide.

We began by organizing a one-day consultative meeting for church leaders in collaboration with the Sierra Leone Red Cross Society. (The Red Cross had also taken part in the Benin workshop.) The fact that the then Minister of Health and the Chief Medical Officer both attended the meeting demonstrated the importance that the government itself attached to the community-based health care approach.

The next step was a three-phase workshop for health workers employed either in CHASL institutions or in governmental or in other non-governmental organizations (NGOs). This process began in late 1990 and finished in 1993. It took place in the Eastern, Southern and Northern Provinces.

The objective of these workshops was to train trainers who would then be equipped with the skills necessary to implement CBHC/D in their districts, chiefdoms and villages.

Today, 50 participants from CHASL institutions, NGOs and government have received certificates of successful training. However, without the backing of their organizations, training in CBHC/D would not ensure implementation. It was particularly important to convince CHASL member institutions of the concept.

#### **CBHC/D promotion through CHASL**

As well as the training programmes, CHASL members have received constant reminders of how this new approach could improve their ministry of healing. CBHC/D has been explained in our newsletters and discussed at our regular CHASL meetings.

Several CHASL member institutions have already taken up CBHC/D as policy. For example, United Methodist Church (UMC) now encourages its use throughout its health and development programmes. It has asked CHASL to conduct seminars for health workers involved in UMC health and development programmes. These have taken place at town and village levels and in both English and the vernacular. Two UMC members have been to India for advanced instruction in CBHC/D. In December 1993, the Bishop launched the UMC's first pilot project in three villages in Pa Lokko.

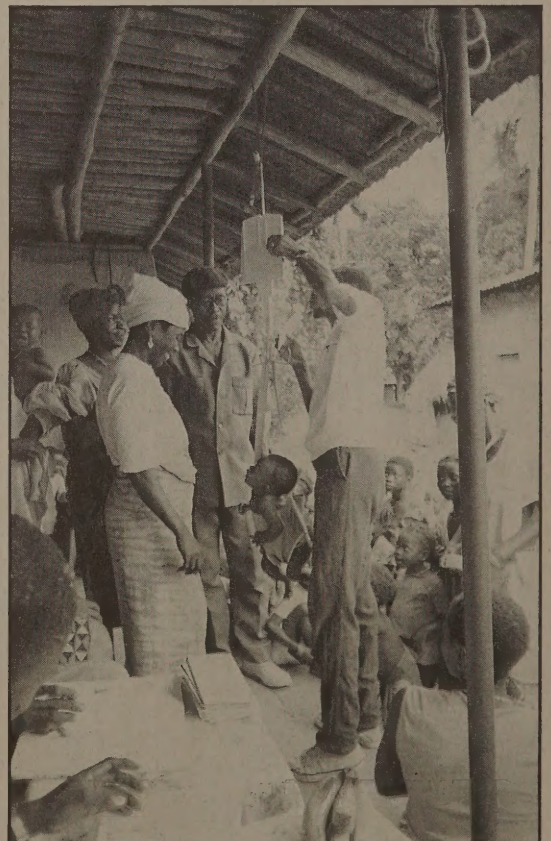
The Baptist Convention has also taken a keen interest in CBHC/D and has developed its own programme. Of all the church groups in Sierra Leone, the Baptist Convention has the largest number of people trained by CHASL in CBHC/D. One member of staff has been sent for advanced instruction at AMREF, Nairobi.

The Bishop of the Anglican Diocese of Freetown, who has had three members trained, has also been impressed with the approach. He recently invited CHASL to attend part of a 5-day residential course for priests, deacons and ordinands. This provided CHASL with the opportunity to share aspects of CBHC/D, such as community involvement, with a theological group. The sessions were well-received and CHASL was later invited to give a session to students at the Anglican theological college.

Most recently, CHASL has had an opportunity to introduce the concepts of CBHC/D to the general public. Since February 1994, we have been giving talks on a Christian radio station about the issues involved. It has been a pleasure to introduce CBHC/D to non-health personnel. More and more, health is being seen as the concern of everyone and not just doctors and nurses.

#### **The CHASL pilot project**

A pilot project in community-based health care and development has also been crucial to our



Marion Morgan

Malnutrition rates have almost halved with the introduction of growth monitoring.

success. By demonstrating that the concept works in practice, it has been possible to convince many more people.

The two main goals of the pilot project reflect the principles of CBHC/D, namely:

- to enable communities to identify their needs and to empower them to find solutions to their health problems. (This is to be achieved with a minimum of "outside" intervention);
- to improve the overall physical, mental and spiritual welfare of the people.

The process of setting up the pilot project began at almost the same time as the training process. In fact, among those trained were two young men recruited from the communities that we hoped to reach. One was a qualified teacher and the other, a trainee pastor. They helped us set up meetings and acted as interpreters for us in our five selected villages.

We collected information in these villages using rapid assessment surveys, observation, community meetings, interviews and focus group discussions. Regular meetings with groups, such as elders, women, youth, farmers associations and traditional birth attendants (TBAs), provided an opportunity for the CHASL team to interact with the villagers. They also helped us to learn what steps the communities had already taken in their development, and what the communities felt their real needs to be.

The people who took part in these meetings expressed an encouraging enthusiasm towards the idea of working together to meet their needs. Three of the villages decided to form Village Development Committees (VDCs) through which to coordinate activities.

### **Participatory training**

Four representatives from each of the five villages involved were given training. They were introduced to the concept of CBHC/D and helped to develop skills in health and development, community involvement/participation and simple book-keeping. These trainees included women and youth leaders and VDC chairpersons.

The village meetings had identified various community development needs. For example, a training programme for TBAs was needed. All five villages had working birth attendants but these women were untrained.

Farmers had said that they needed small loans during the farming season. In the three villages where there were VDCs, CHASL provided the financial assistance for a revolving loan scheme. Training in CBHC/D made it possible for the VDCs to work out the rate of interest, the method of payment and the schedule for repayment of loans. This programme has now been working well for three years.

The village meetings also established that more local schools were needed. When children were not in school, they played in the forests or near streams which often proved dangerous. Those trained in CBHC/D took ideas about how to organize and run a school back into their villages. Two new village schools were later set up.

It was also felt that children's nutrition needed to be monitored. Having learnt the skills involved in setting up growth monitoring programmes, CBHC/D programmes in the villages produced significant reductions in rates of child malnutrition.

The experience of planning and putting the plans into action in the villages has taken time, but it has helped people to appreciate their resources and to appreciate how to use them profitably.



CHASL's executive director, Marion Morgan (right) with Dame Nita Barrow, a former director of CMC.

As a result, the need for community participation through CBHC/D is becoming clearer, both to the people themselves and to many of the agencies involved in health work.

### Looking ahead

Heartened by the achievement in rural communities, CHASL has embarked on a similar project in the urban area in the country's capital, Freetown. Meetings have included a one-day awareness seminar for community leaders, and a three-day CBHC/D workshop for youth. Five groups have completed a baseline community self-survey and these are currently being analyzed.

We are also receiving requests from rural villages who wish to work with us in CBHC/D. Training institutions have also asked us to help them include CBHC/D in their curricula.

The potential for CBHC/D in Sierra Leone is immense. My hope is that more and more people will embrace the CBHC/D approach, and that it will become the road to health in the 21st century.

CHASL is proving to be a very capable agent of change. From having only one CBHC/D trainer (myself) in 1990, we now have three trainers, all of whom are local people. We have established a successful pilot project through which to demonstrate the potential contribution of CBHC/D to health and development. We are also continuing to publicise its benefits. Everyday, we are convincing more and more people that CBHC/D is a concept to which they should commit themselves. Coordination is helping to extend the provision of health care to people not yet reached.

*\*Marion Morgan is moderator of CMC's Health Working Group.*

### CASE STUDIES



## UGANDA BENEFITING FROM CENTRAL SUPPLIES

*Covering the cost of the pharmaceutical bill is often one of the biggest headaches for those in charge of church medical services. But Protestant and Catholic churches in Uganda are lucky. In response to the crisis situation they faced during the 1970s, church health groups came together to support the formation of the Joint Medical Store. Today, the JMS, as it is known, not only supplies church health institutions with a reliable supply of low-price pharmaceuticals but also it provides a repair service to relieve the frustration when medical equipment breaks down. Frank Winnubst, manager of the Joint Medical Store, tells the story of this remarkable example of the benefits of cooperation.*

Thirty years ago, Uganda was a relatively prosperous country. The people enjoyed a limited but effective health service. The pharmaceutical companies were in competition with one another and this had the effect of keeping prices down. Church health units could choose to buy their pharmaceutical and medical supplies either from government-run "Central Medical Stores" or from private pharmacies.

But during the decade of the 1970s, war tore Uganda apart. The infrastructure virtually collapsed and the health sector suffered serious damage. Both the government central stores and the private pharmacies disappeared. In response to the situation, Catholic and Protestant Churches in Uganda founded the Joint Medical Store in 1979. Its primary role at that time was to receive and distribute relief aid which was mainly in the form of medicines.



Health personnel working in Christian programmes in Uganda have come to rely on economical and regular supplies of pharmaceuticals and other medical products.

### Peace and progress

When the situation in Uganda stabilised in the second half of the eighties, JMS, as it became known, managed to transform itself. It became a sustainable supplier not only of pharmaceutical and medical supplies but also of technical and pharmaceutical services. It also began to supply the spare parts and educational services needed to support such an enterprise. Its success in transformation has been astounding. JMS is now buying pharmaceuticals and medical equipment on behalf of 35 hospitals, 35 health centres and 200 dispensaries. These 270 units form the combined health services of the Catholic and

Protestant Churches in Uganda. Together, they are the suppliers of at least 40% of the medical care in the country.

JMS procures and sells on a non-profit basis. Essential drugs, medical supplies, lab chemicals and raw materials are available to all the health units registered either with the Uganda Catholic Medical Bureau or the Uganda Protestant Medical Bureau. Syrups, lotions, ointments, eye and ear drops and suppositories are produced in JMS's own production unit. Staff at JMS are also able to provide the hospitals with the

raw materials for production of intravenous (IV) fluids, water for injections and some other wet products. Staff are able to train hospital pharmacy staff in proper production techniques and to visit hospital pharmacies regularly to supervise production processes. As part of its educative service, JMS advises its "customers" on rational drug use and proper drug storage.

As well as these pharmaceutical medical services, JMS offers technical medical services. Staff are available to repair hospital equipment and to organize the supply of equipment and spare parts. JMS can also train hospital technicians in basic maintenance and repairs. Hospitals and clinics using these services pay for them but are often charged at prices far below costs.

### Making it pay

JMS's income from technical services currently covers only 50% of costs while the pharmaceutical Medical Store manages to cover 98% of its costs. However, the Medical Store is a much larger enterprise, involving much more capital than the technical services, and the two sides of JMS together manage to make the operation 95% sustainable overall. Donations from various sources fill the gap and make it possible for JMS to continue to provide its low-cost technical services.



Even during the 1980s, Uganda was continuing to suffer from the destruction caused by the past dictatorship and the war in 1979.

JMS offers services to the Catholic and the Protestant Churches in Uganda that neither would have been able to achieve if working separately. The low prices and the wide range of services are only achievable because JMS is able to take advantage of "economies of scale". Coming together saves the health units of all the member churches both time and money.

For example, JMS is able to offer its products at prices that are below those of most other suppliers. About 80% of the drugs JMS sells cannot be found cheaper elsewhere in Uganda. The remaining 20% may be as expensive as other suppliers but there is the guarantee of quality control.

### **Difficulties**

For JMS, the major constraints are money and staff. Every item that is sold needs to be replaced through procurement. This means that JMS has to ask the health units to pay promptly for what they buy. Despite the fact that JMS margins are very low, many health units would inevitably like to pay less or later. They themselves depend mainly upon the income from patients' fees. However, experience at JMS has shown that a "cash-and-carry" approach works best, and that offering credit is almost always a mistake.

The other constraint is that staff are not always as well-trained, motivated and honest as they should be. Drugs are valuable in poor countries and as a result they sometimes "disappear". JMS management has to pay special attention to staff development because a reliable staff is vital to its successful operation. Staff development requires an integrated approach to pay and conditions, training, career opportunities and delegation. It also requires that management fosters an awareness among the staff that the mission of JMS is to serve God's people.

### **Accountability**

Last, but not least, is the issue of financial accountability. JMS is an initiative in cooperation, but it is also a multi-million dollar business. In our annual report to hospitals, dioceses and donors, the financial position is detailed because the JMS philosophy is that customers and donors have the right to know. JMS carefully monitors its finances in the same way that any profit organization, non-profit organization or any other Church institution should do. At JMS, we believe that our customers are entitled to both quality and continuity of service, as well as accountability, regardless of whether they are companies, patients or parishioners!



J Mohr/WHO

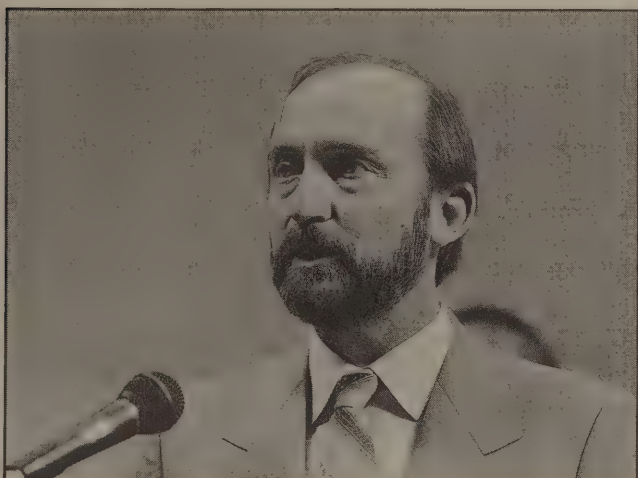
JMS can offer in-hospital training for pharmacists.

# UPDATES FROM AROUND THE WORLD

The Contact editorial team have been in touch with church health coordinating agencies in order to provide more information about activities taking place and plans being made. Here is some of the available news.

## Making plans in South America

CLAI (Latin American Council of Churches) has held its first workshop on the coordination of health activities. Margareta Sköld, from CMC - Churches' Action for Health, travelled to Quito, Ecuador in April to take part in the meeting.



Peter Williams/WCC

Felipe Adolf

The group proposed regional consultations which, if accepted by CLAI's general assembly, will lead to decentralised priority setting as part of regional responsibilities. "We don't want health to be an appendix any more, we want it to be an integrated part of our work," stated Felipe Adolf, general secretary of CLAI.

## French-speaking Africa

The following news from Rwanda was received before the recent tragic turn of events had taken place.

BUFMAR (Bureau des formations médicales agréées du Rwanda) can claim the most outstanding success story in francophone Africa. The agency, which was formed in 1977, represents eight Christian churches, including one Catholic, one Seventh Day Adventist and one Pentecostal.

BUFMAR reports regular new achievements. For example, recent attempts to increase pharmaceutical purchasing from within Africa have proved fruitful. According to BUFMAR's 1992 annual report, pharmaceutical purchasing now comprises 10% from Rwandan sources (including 6% from BUFMAR's own production) while imports from Kenya have increased to 10%. The remaining 80% is imported from Europe.

BUFMAR is also in the process of building up its IEC (information, education and communication) department. Programmes have already started, and *Contribuons à la santé communautaire au Rwanda*, a substantial and well-produced guide to IEC has been developed to support the department's work. However, according to managing director Paul de Roo: "As soon as funds are found to expand the work further, the department will begin to make a major contribution to the primary health care programme."



Front cover drawing from BUFMAR's "Let's contribute to community health in Rwanda."

Coordination efforts exist in several other francophone countries including Benin, Cameroon, Central African Republic, Guinea Conakry, Mali and Zaire. These agencies have tremendous potential, particularly in helping to ease the difficulties of acquiring reasonably-priced drug supplies and in vital information sharing. However, the individualistic nature of many churches coupled with social, economic and political problems have made collaboration difficult. For example, there were great hopes of cooperation in Burundi until the country fell into chaos.

Most hopeful is the news from Mali where 30-40 members of the Association Protestante de la Santé au Mali now meet to share information. The Association also offers access to journals and other materials from abroad. According to Henrietta Hunse: "We are still feeling our way but we hope in the future to become involved with organizing medical supplies and drugs."

### **Liberia: Ecumenism triumphs**

Ecumenism in health has triumphed in Liberia. This is thanks to the contribution CHAL (Christian Health Association in Liberia) has made towards health and peace during the course of the civil war which broke out in December 1989.

For example, CHAL ensured that the Expanded Programme of Immunization (EPI) continued after the United Nations had given up. It provided expertise for programmes helping children traumatised by what had happened to them during the war. Some had seen their parents or teachers die in front of their eyes, others had been used as child soldiers. CHAL also worked hard to ensure that medical and relief supplies for rural Liberia were exempted from the import embargo.

Perhaps even more important was CHAL's "Healing and Reconciliation Program". Today, this programme continues to enable pastors, church leaders, teachers and health workers to learn how to help individuals suffering emotional problems resulting from the war. Once trained, these CHAL workers run workshops where

people begin to come to terms with what they have lost. They also begin to deal with their feelings about those who were the cause of their losses.

A major contribution to CHAL's success during the war was the reputation that it had established prior to the war. CHAL staff were well known for their commitment to the health services of all church denominations in Liberia. The respect in which they were held gave them great freedom of movement during the war, sometimes even greater freedom than that of the relief agencies.



CHAL's logo

But an equally important contribution was made by the leadership shown by director, Elizabeth Mulbah. "She provided the type of courageous and faithful leadership that very few people could have achieved," according to Jeannette Isaacson Kpissay, secretary of the US-based CHAL Support Group. Like many of her brave staff team, she continued her work even after her family had been separated.

Since the end of the war, the contribution that Elizabeth Mulbah made to the peace process in Liberia has been recognised and rewarded. In January 1994, she began a six-month secondment to the Office of the Special Representative of the UN Secretary General in New York.



### **Botswana: Building plans**

The executive committee of the Association of Medical Missions for Botswana has developed a proposal to build a Community Service Centre. It would provide new facilities to the Association which should, in the long term, make the Association more self-sufficient. Rooms in the building would be rented out.

AMMB was founded in 1974 by three mission hospitals and now provides primary health care for about 20% of Botswana's population.

### **Indonesia: Centralisation**

The Christian coordinating agency in Indonesia is now centralised in Jakarta. A secretariat of PELKESI, known in English as ICAHS, Indonesian Christian Association for Health Services, has been established at CCI Cikini Hospital. It is supported by board members who are mainly based in Jakarta and Central Java. ICAHS executive secretary is Paltak Pasaribu.

### **Nigeria: PAR working to fight AIDS**

AIDS coordinator, Rayika Booth who works with CHAN (Christian Health Association of Nigeria) took part in a workshop on Participatory Action Research (PAR) organized by CMC - Churches' Action for Health in Uganda. The following is an extract from a letter that we received from her recently.

*"I have been so excited about PAR since my return from Kampala. I have introduced it to the CHAN Programme on AIDS as a method of developing materials with various groups. I have personally held Focus Group Discussions with youth groups - all from various churches. It is quite interesting to hear them talk and to get their ideas as to what is best and what can be done for that group regarding AIDS control."*

### **Lesotho: Crisis for church hospitals**

The nine hospitals and over seventy church-owned clinics in Lesotho represented by PHAL (Private Health Association of Lesotho) are threatened with closure as a result of the financial crisis. As we went to press, PHAL's new executive secretary, Eliazar Petlane, was hoping to attend the World Health Assembly in Geneva. There, he hoped to discuss with others

the severe difficulties facing Lesotho's Christian health institutions.

### **Zimbabwe: Training begins for home care**

ZACH (Zimbabwe Association of Church-related Hospitals) has started running workshops for community-based home care. According to executive secretary, R D Nyenya: "These workshops could not have come at a much better time than this." He says that many hospitals now have what would be termed "B" beds, or floor beds, emphasising the need to take care of more patients in their own homes.

ZACH is organizing exchange visits in which community-based home care programme coordinators would visit other similar programmes operating in the country. The Association hopes to give small cash grants to help start new programmes.



More and more hospital beds are taken by AIDS patients. There is a need to develop community-based home care programmes.

L Gubb/WHO

### **Where are there coordinating agencies?**

We have not been able to include information about all of the coordinating agencies in Africa, Caribbean, Asia, Pacific and Latin America. However, upon request we will be happy to let you know if there is a coordinating agency in any particular country.

# A VISION FOR THE FUTURE

By Daleep Mukarji\*

*The Christian contribution to health care is recognised both in developed and developing countries. Christians have often pioneered efforts in community health, the training of health professionals and service to the disadvantaged. Today, the heritage of mission hospitals, rehabilitation centres and community programmes provide half the health services available in some countries. Given the present crisis in health care provision, how should these facilities attempt to complement and extend government health services? What is our "Vision for the future?"*

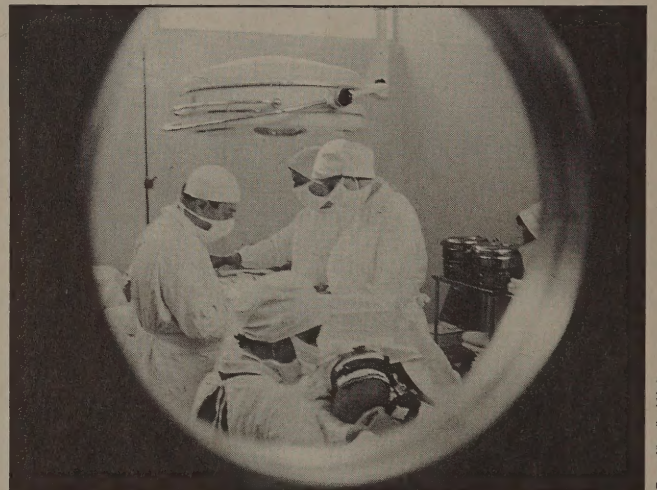
Since the 1970's, CMC has been actively involved in efforts to bring Christian health institutions and individuals together to form national ecumenical coordinating agencies. In September 1991 an International Consultation of National/Regional Christian Coordinating Agencies in health took place in Delhi, India, sponsored by the CMC in collaboration with CMAI (Christian Medical Association of India)\*\*. This gave an opportunity of sharing, learning and planning for the future.

Christian health and medical work is in a crisis today. Hospitals are closing. Governments cannot provide support. Staffing is difficult. There is a severe shortage of funds for drugs and basic equipment. Donors seem unwilling to support institutions. In many places innovative training, community programmes and outreach work have been started but they are facing difficulties with funding, staffing and sustainability.

Underlying all this, there is a lack of knowledge and commitment to the healing ministry of the Church. Healing has not been seen as an integral component of mission. Yet "mission" is defined as preaching, teaching and healing. Wholeness is recognised to be God's intention for individuals, society and the whole creation. The healing ministry of the Church should announce God's work in salvation through Jesus Christ, bringing wholeness and justice to the world.

In many developed countries the hospitals have become secularised. Technology, professionalism and the intervention of the state has somehow allowed the Church to abdicate its responsibility in health and healing. The

work of hospitals should not be the primary agenda of the healing ministry. The Church in its healing ministry should look to the larger issues of the prevention of disease; the promotion of health; the building up of a healthy and just society; advocacy for appropriate health care services and the special needs of women,



Technology has somehow allowed the Church to abdicate its responsibility to health and healing.

the disabled, the elderly and those with terminal illness. In a broken world with broken homes, relationships, and people, there is a crying need for a ministry of reconciliation and renewal that restores relationships and builds healthy communities.

Specific challenges for the future in Christian health and medical work:

## 1. Promotion of the healing ministry

Equip the churches to rediscover and revitalise this aspect of mission. This would require biblical and theological reflection on the "why" and the "how" of Christian involvement in health and healing.



The Church must continue to encourage community-based health care.

## 2. Ethical issues

The practice of medicine and the introduction of new technologies raise basic questions about the value and meaning of life. They raise questions about the role of professionals and governments and the views of the Church in this situation. There are also ethical issues surrounding the distribution of health care, the policies of pharmaceutical multinationals in the manufacturing and marketing of their products, and the behaviour of doctors in drug prescribing. An environment in which there is too much competition between hospitals and health professionals often leads to unethical and dangerous practices.

## 3. Community-based health care

The Church must continue to support health services that encourage people to be responsible for their own health care. It must also provide leadership and support for low-cost, effective interventions that make a real difference to health status. For example, Participatory Action Research on AIDS has helped groups of local people to identify their main problems and helped them to organize some solutions as a community.

## 4. Emerging health problems

When new health concerns are revealed, they need to be given special attention. These include AIDS, care of the elderly, environment and health, substance abuse, women's health issues and mental health.

**5. Equipping local congregations to become healing communities in mission.** The healing

ministry must be understood and practised at the level of local congregations. This would enable them to become agents of healing while providing them with a healing experience within themselves.

**6. Networking and exchange:** Both within countries and between countries there needs to be greater sharing, learning and growing together in the healing ministry. This requires regional, sub-regional and international programmes for exchange, regular meetings and mechanisms for co-operation. Christian coordinating agencies cannot work in isolation. They need the solidarity and partnership that such a process can provide.

Coordinating agencies in health can become involved in any of the above activities. Although national ecumenical coordinating agencies have no authority or executive control over their member institutes, they can provide inspiration and leadership for collaboration.

At the same time, the coordinating agencies need to concentrate on equipping themselves to help their members in human resource development, management and the promotion of the healing ministry. For it is these aspects of the work of church health-related coordinating agencies that will continue to shape their vision for the future .

\* Daleep Mukarji, MD, is former general secretary of Christian Medical Association of India (CMAI)\*\*. CMAI brings together Protestant and Orthodox churches in India.



Far left: Daleep Mukarji, former general secretary of Christian Medical Association of India, with CMAI president (centre) and vice president (right).

## ANNOUNCEMENTS

### WCC welcomes Daleep Mukarji

In March 1994, Daleep Mukarji, former general secretary of the Christian Medical Association of India, took up his new position as executive secretary for Urban Rural Mission with Unit 11, World Council of Churches. All of us welcome him to our Unit and extend to him and his family all good wishes for their future health and happiness in Geneva.

Cherian Thomas has replaced Daleep as general secretary of Christian Medical Association of India. Address: Plot No 2, A-3 Local Shopping Centre, Janakpuri, New Delhi - 110058, India.

**May we remind you? We have changed our name to:**

### CMC - Churches' Action for Health

Following restructuring within the WCC, we have become part of Unit 2. Our former name, Christian Medical Commission is no longer appropriate since our structure is no longer that of a commission. Our mission and location remain unchanged.

### Arabic speaking?

If you would like to receive the selected issues of *Contact* that are translated into Arabic, please let us know. We shall be happy to include you in the mailing list.

CONTACT is the periodical publication of "CMC - Churches' Action for Health" of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya, and Arabic in Cyprus. Present production exceeds 32,000 copies.

CONTACT deals with varied aspects of the community's involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to CONTACT, the bimonthly publication of CMC - Churches' Action for Health, WCC.

Editorial Committee: Kofi Asante, Eva Ombaka, Erlinda Senturias, Margareta Sköld and Diana Smith; Editor: Diana Smith; Design: Michel Paysant.

Printed on recycled paper by Imprimerie Arduino. Mailing List: Fernande Chandrasekharan. All correspondence should be addressed to: CMC / WCC, P.O. Box 2100, CH - 1211 Geneva 2, Switzerland. Tel: 41 22 791 61 11. Fax: 41 22 791 03 61

The average cost of producing and mailing each copy of CONTACT is Swiss francs 4 (US\$ 2.50), which totals Sfr 24 (US\$ 15) per year for six issues. Readers who can afford it are strongly encouraged to subscribe to CONTACT to cover these costs. Please note that orders of back issues of CONTACT are charged at the above rate.